## EVIDENCE OF INSURABILITY FORM

a CIGNA Company (herein called the Insurance Company)

For info and customer service call 1-800-345-9458

- The applicant must sign and date this form.
- This form cannot be considered unless received within 30 days of the date it is dated.

Return completed form to in the envelope provided to CIGNA Group Insurance P.O. Box 203101 Lehigh Valley, PA 18003-9924 Fax: 800.440.0856



Important: Please enter all dates in mm/dd/yyyy format. Please print (preferably in black ink).

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EMPLOYER US	E (MANDATORY DATA NEE	DED): In or	der to process t	his application, th	e employer i	must comple	ete this
EMPLOYER	Williamson County			Policy	FLX-9	)64517; FI	LX- 964518
CLASS	LOCATION	DATE OF HIRE		ANNUAL SALARY		VERIFIE BY	ED
REASON FOR R  LATE ENTRA	EQUEST: NEW HIRE CANT	INITIAL E	NROLLMENT	TEVENT 🗆 ON	GOING EN	ROLLMEN	NT EVENT
			VOLUNTAR	RY EMPLOYEE	VOL	UNTARY S	SPOUSE
NEW COVERAG	GE (TOTAL)						
CURRENT COV	ERAGE						
GUARANTEED REQUESTED IN	COVERAGE PORTION OF ICREASE						
AMOUNT SUBJ	ECT TO MEDICAL EVIDENC	CE					
		EMPLO	YEE SECTION				
☐ Mr. ☐ Mrs. ☐	Ms. (Check One)						
Employee			Social Security		D' 4		
			# City		Birtho State		
Address	Home	`		, •		Z.ip	
Work Phone	Phone		Employee	e ID #		Sex: $\square$ M	□F
In order to confirm signature:	n your election, please provide yo	ur				Date	
signature.						_ Duic	
	COMPLI	ETE IF ELEC	TING SPOUSE	COVERAGE			
☐ I am currently is	married and my date of marriage						
Spouse Name							
(First)		(Last)		Soci	al Security #		
Birthdate		Sex: □ M					
		1					
	701		PORTANT				
	Read the Agreements and A			vs if it is needed. e the form in the sp	ace provide	ed.	
Complete the emplo	yee and spouse info in this section if		_				nter than the
guaranteed amount of	or are applying for Life Insurance mo	ore than 31 days	after you were el	igible for the insuranc	ee.	_	
	F	Height and V	Veight Inform	nation			
Employee			Spouse				
Height ft	in Weight lbs	3	Height	ft in	Weight		lbs
Please	indicate your answers for each	question in tl	his section by cl	hecking the Yes or	No box for	the question	l <b>.</b>
	ears has the proposed insured bee						
-	with any of the conditions shown beloedical professional he/she has or may		ne conditions sho	own below			
•	eated by a medical professional fo	•					1
						Employee	Spouse Yes No
						Yes No	
	tack or stroke?	\ <b>**</b> • • •		1			
	ther than Nonmelanoma Skin Ca na or Chronic Obstructive Pulmo			eukemia?			
	tion or AIDS?	nary Discase (	COID):				
	Hepatitis C or Cirrhosis of the liv	ver?					
	r drug abuse or dependency?						
	5 years has the proposed insured luence (DUI) conviction?	had a Driving	g While Intoxica	ated (DWI) or a Dri	ving		

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Fold and staple to conceal health questions. Return application to your employer. Be sure to make a copy for your own records.

TL-009320 (TN) 11/2011

Name	Social Securit	ty#

## ♦ ♦ ♦ AGREEMENTS AND AUTHORIZATION ♦ ♦ ♦

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

- (1) This request will be a part of the policy that provides the insurance.
- (2) I may need to provide more medical info.
- (3) I may need to take medical tests and report the results to the Insurance Company.
- (4) I must report any change in my health that happens before the insurance is effective.
- (5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

**Authorization**. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

	Employee's Signature	Month/Day/Year	Spouse's Signature	Month/Day/Year	
Sign Here			(If applying for insurance for your spouse)		

*Notice:* Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.

Return to your employer. Be sure to make a copy for your own records.

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